ARIZONA FOOT & ANKLE SURGERY

480.812.3636
FAX 480.812.3637

PATIENT INFORMATION

Last Name _______________________________ First Name ________________________Middle Initial___________

Address ____ City___________________________________

State ________________________ Zip Code _________________ e-mail ____________________________________

Secondary Address ____

Home # _______________________________ Work # ________________________________Ext.__________

Cell # ______________________________________ Other # _________________________________

Birth date _________________________ SSN ___________________________ Sex (Male / Female) Age_______

Marital Status --- Single / Married / Divorced / Widow / Separated

Family Doctor ___________________________________ Referred By _____________________________________

PRIMARY COVERAGE

Relationship --- Myself / Spouse / Child / Other

Insured Person Name ____ SSN ___________________________

Date of Birth of Insured Person ____ Sex _______________

Name of Insurance Co. ____

Policy # ____ Group # _______________________________________

SECONDARY COVERAGE

Relationship --- Myself / Spouse / Child / Other

Insured Person Name ____ SSN __________________________

Date of Birth of Insured Person ____ Sex ______________

Name of Insurance Co. ____

Policy # ____ Group # _____________________________________

MEDICAL HISTORY

General State of Health ☐ Good ☐ Fair ☐ Poor Height_________ Weight_________

Allergies/Sensitivities (**Yes** / **No**) (i.e.- medications, metals, latex, tape, ETC…) **If yes, please list** _________________

_____________________ _______________________ ______________________ ___________________________

Current Medications (**Yes / No**) **If yes, please list** ____________________________ ___________________________

____________________ _______________________ _______________________ ________________________

Previous Surgeries & Dates ___________________ _____________________ Complications? (Y / N) ________

Have you ever had the following medical conditions: (circle) Are you pregnant? (Yes / No / Maybe)

Y / N Anemia
Y / N Asthma
Y / N Circulation Problems
Y / N Foot Numbness
Y / N Hepatitis
Y / N Liver Disease
Y / N Phlebitis
Y / N Past Swelling Feet/Ankles
Y / N Varicose Veins
Y / N Anxiety / Depression
Y / N Blood Disease
Y / N Gout
Y / N Diabetes
Y / N High Blood Pressure
Y / N High Cholesterol
Y / N Stomach Conditions
Y / N Thyroid Dz (hypo/hyper)
Y / N Arthritis (Type?) _____________________
Y / N Cancer (Type?) ______________________
Y / N Epilepsy / Seizures
Y / N Heart Conditions (explain) _____________
Y / N Menopause
Y / N Neurological Conditions _______________
Y / N Stroke
Y / N Tuberculosis

Other Medical Conditions____

Which of these illnesses are in your immediate family? ____

Describe current problem – side (R) (L) (Both) ____

How long have you had the problem? __________________ Previous treatment? ________________________________

Do you smoke tobacco? Y / N If YES → How much? ___Pack(s)/day How many years? ___ If NO → year quit______

Do you drink alcohol? Y / N If YES → How much? __________ How many years? ______ If NO → year quit______

Occupation?___________________________________Activities/Hobbies?_______________________________________

I hereby give Dr. Chad L. Thompson permission to treat me or my dependents as necessary. I understand my insurance company may assist me in paying all medical costs, but I am ultimately responsible for all medical services rendered and if necessary, I agree to pay all reasonable and customary collection fees and/or attorney's fees that may be incurred due to any delinquent accounts I may have. I authorize the release of any medical information necessary to process my claim to my insurance company. I Furthermore authorize payment of medial benefits to my physician, directly, for services rendered. I understand that I am financially responsible for my bill. I understand that my co pay is due at the time services are rendered. I am also responsible for understanding all the policies and benefits of my medical insurance.

Signature ____ Date __________________________

I certify that I have received a copy of and understand Arizona Foot and Ankle Surgery's privacy policy and that I have had all of my questions answered by the staff.

Signature ____ Date __________________________